BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

THOMAS PAINTER Claimant VS. **KAW VALLEY FRAMING COMPONENTS** Respondent AND **COMMERCE & INDUSTRY INS. CO.** Insurance Carrier	)	Docket No. 1,046,376

ORDER

Respondent and its insurance carrier (respondent) requested review of the July 22, 2011 Award by Administrative Law Judge (ALJ) Kenneth J. Hursh. The Board heard oral argument on November 2, 2011. E.L. Lee Kinch, of Wichita, Kansas was appointed as a Board Member Pro Tem in this matter. Gary Terrill, recently appointed Board Member, had a conflict in this matter. Therefore, Mr. Kinch remained as the Board Member Pro Tem.

APPEARANCES

John E. Redmond, of Kansas City, Missouri, appeared for the claimant. William G. Belden, of Merriam, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award. At oral argument to the Board, the parties stipulated that the medical records of Barbara Winkleman, D.O. and the records from the Elizabeth Layton Center are part of this record and may be considered by the Board in determining this matter.

ISSUES

The Administrative Law Judge found claimant to be permanently and totally disabled and also awarded claimant future medical benefits. Respondent contends that claimant has failed to prove that his inability to work stems from the accident on January 7, 2004. Claimant's permanent total disability stems from factors not associated with the accident, like his age and education. Under K.S.A. 44-510c(a)(2), permanent total disability must be "on account of the injury". Respondent requests review of whether claimant is permanently and totally disabled when there is no substantial competent evidence that claimant was rendered permanently incapable of engaging in substantial gainful employment due the "injury" sustained on January 7, 2004. Respondent argues that the ALJ's Award should be reversed and compensation denied.

Claimant contends that his inability to work comes directly from the effects of the accident, and subsequent treatment which causes him to suffer debilitating headaches along with shoulder and neck problems. Claimant contends that the ALJ's Award should be affirmed.

FINDINGS OF FACT

Claimant began working for respondent, a builder of prefabricated homes, in August 2003, as a material handler. His job duties required that he supply lumber to customers for the construction of trusses and other odd jobs around the shop, such as installing air compressors. On January 7, 2001, claimant and another worker were driving two fork lifts together, loading a stack of constructed walls onto a semitrailer truck. As they were moving the walls, a side began to sag and claimant jumped off of his fork lift to try to steady the walls. As claimant ran to the sagging part, he tripped over a small cart, landing on a rock floor, striking his left shoulder and head. After the fall, claimant did not seek medical treatment immediately. He did complain of severe pain after that Friday afternoon accident.

On Monday, claimant was referred to Corporate Care and Rehabilitation for treatment of complaints of rib pain. He underwent x-rays, and was diagnosed with non-displaced rib fractures. He was examined by Robert R. Brown, D.O., and placed on temporary light duty, but respondent was unable to accommodate Dr. Brown's restrictions. Claimant has not been able to return to work since the accident.

When claimant first began receiving treatment with Corporate Care, he reported only rib pain to Dr. Brown. This was true for several visits. However, by February 11, 2004, claimant reported that the physical therapy had caused pain in his left shoulder, that radiated into the upper back, neck and head. This pain was accompanied with muscle spasm and a headache which claimant described as a migraine. Claimant has a history of migraine headaches. An MRI of claimant's left shoulder displayed a 50-70 percent tear of the left supraspinatus tendon. An orthopedic referral was then recommended.

Claimant was referred to board certified orthopedic surgeon Brian J. Divelbiss, M.D. for an examination, on March 5, 2004. After review of the MRI, Dr. Divelbiss confirmed the partial thickness tear of the left rotator cuff. The physical examination revealed significantly decreased range of motion particularly flexion, abduction and internal rotation. Surgery was recommended and performed on April 19, 2004, consisting of a left shoulder arthroscopy with extensive debridement, arthroscopic acromioplasty and distal clavicle excision. Subsequent to the surgery, claimant developed recurrent swelling around the shoulder region with significant range of motion limitations. Swelling around the shoulder and supraclavicular region began to give claimant migraine headaches again. It was recommended that claimant be referred to a neurologist for treatment of the headaches. Aristocort and Lidocaine injections into the shoulder brought instant relief of the shoulder pain, but had no effect on the headaches. An MRI of the cervical spine performed on August 12, 2004, revealed degenerative disc disease at C3-4, C4-5 and C5-6 with posterior disc bulging and osteophytosis. Claimant's range of motion in his shoulder continued to slowly deteriorate.

The record contains medical information from several sources dealing with various attempts to alleviate claimant's symptoms with physical therapy, none successfully. The records from SERC therapy identify left shoulder pain, constant headaches, left upper trapezius and cervical pain over a several month period. Claimant constantly complained of increased pain and headaches from the physical therapy activities.

Physical Medicine and Rehabilitation specialist James S. Zarr, M.D. provided claimant with pain medication and electrical stimulators to no avail. Claimant was referred to PainCare, a pain management company, for epidural steroid injections into the first occipital nerve. This treatment resulted in a reduction of the numbness and tingling in claimant's arms and a reduction in tenderness. However, according to Daniel Bruning, M.D. at PainCare, the headaches remained along with some shoulder pain.

Claimant was referred to board certified neurologist Charles L. Weinstein, M.D. in January, 2005. Dr. Weinstein placed claimant on a series of narcotic medications, prescribing Amitriptyline, Depakote and Paxil to take on a daily basis. These provided no noticeable benefit. Claimant remained under the care of Dr. Weinstein for several years, reaching maximum medical improvement (MMI) on May 22, 2008. During this time, claimant was placed on numerous different medications to help alleviate the migraine headaches, with no improvement. Claimant also displayed significant psychiatric distress, predominantly depressive symptoms to Dr. Weinstein.

Claimant was referred to Patrick L. Hughes, M.D., of Psychiatric & Family Services of Greater Kansas City, for an evaluation on November 1, 2005. Claimant's headaches were noted to have begun when physical therapy was started. The headaches continued

on an almost daily basis. Claimant self reported as being "currently medically disabled".[1] Claimant also displayed signs of depression, insomnia, irritability, poor concentration and a loss of libido. Dr. Hughes was unable to explain the mechanism by which the shoulder injury led to the development of the headaches. But, he acknowledged that Dr. Weinstein noted a relationship. Claimant provided Dr. Hughes with a history of striking his head at the time of the initial fall in 2004. Claimant also attributed the headaches to something at or after the shoulder surgery.

During the interview, Dr. Hughes noted a lack of any indication of significant relentless pain. He determined that claimant developed Major Depression, a genetically caused biochemical disturbance of the brain that he had not found to be causally attributable to a workplace injury or subsequent surgery. Dr. Hughes determined that claimant's depression was already active and generating significant headaches. He recommended that Dr. Weinstein increase the level of antidepressant medication which should bring about a full resolution of claimant's depressive symptoms.

Dr. Hughes expressed concern that claimant displayed either malingering or an "unconscious" Pain Disorder with psychological features. He opined that unrelenting headaches, despite all of the pharmacotherapy being provided by Dr. Weinstein, is highly unusual. He described claimant's report of virtual non-function from the headaches as moderately-theatrical.[2] Dr. Hughes did not seem to question the existence of headaches, only the totally disabling aspect of those headaches. Additionally, he did not feel that claimant's ongoing headaches were causally related to the workplace injury.

Claimant was referred by respondent on April 3, 2006, to Daniel J. Keyser, Ph. D., for an evaluation of his ongoing headaches. Dr. Keyser administered several tests, including the MMPI, The Taylor-Johnson Temperament Analysis and the Problem Rating Scale. Claimant returned for a total of six visits with the last exam being on March 13, 2006. The possibility of claimant being a malingerer was raised in his report. However, Dr. Keyser did not find claimant to be a malingering patient. Claimant's ongoing problems appeared to stem from the lack of progress on his pain treatment. Biofeedback was utilized as a treatment modality with limited success. Claimant did report less frequent and less intense headaches. Dr. Keyser opined that claimant would have to live with some level of pain as he was not able to totally eliminate claimant's pain and headaches. He also noted swelling around claimant's neck which he identified as a possible source of the headaches.

Claimant was referred by respondent to board certified physical medicine and rehabilitation specialist Vito J. Carabetta, M.D. on January 23, 2007. Claimant reported

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[1] R.H. Trans., Cl. Ex. 1 at 141 (Dr. Hughes' Nov. 1, 2005 report at 2).

[2] *Id.*, Cl. Ex. 1 at 144 (Dr. Hughes' Nov. 1, 2005 report at 5).

to Dr. Carabetta that he struck his head at the time of the fall, and was dazed but not unconscious. Claimant reported the shoulder surgery and physical therapy as possible sources for the headaches. But he also claimed that the headaches were ongoing, apparently from the outset. None of the treatments, including the physical therapy, pain medications, biofeedback injections or relaxation techniques were of permanent benefit for the headaches. A TENS unit did help somewhat.

During the physical examination, claimant was found to have a normal range of motion of the cervical spine. The range of motion of the left shoulder was somewhat limited at the extreme end-range. Claimant complained of the ongoing headaches which Dr. Carabetta found to be more likely connected to claimant's medications rather than the cervical spine. Claimant was diagnosed with post left shoulder arthroscopy and post-traumatic cephalgia (headache). His only suggestion was proper management of claimant's medications.

Claimant was reevaluated by Dr. Hughes on November 29, 2007. He noted that Dr. Weinstein followed through with his initial psychiatric recommendations to increase claimant's medications. However, claimant continued to experience recurrent severe headaches and Major Depression symptoms. Claimant experiences low level headaches daily, with "bad headaches" lasting 3-7 days, 3 times per month. Claimant was again diagnosed with Major Depression, not attributable to the January 2004 accident. However, again the headaches were seen as being real, and intense treatment was recommended. Dr. Hughes expressed confidence that ongoing medication and continued treatment with Dr. Weinstein would prove beneficial to claimant. Dr. Hughes observed that claimant had been evaluated by Dr. Ryan who also noted the need for ongoing psychiatric treatment. Dr. Weinstein recommended claimant be referred to a well-regarded headache center in Michigan. An MRI performed on January 4, 2007, identified multiple levels of degenerative disc disease from C3-4 to C5-6.

On March 27, 2008, claimant was evaluated at the Michigan Head Pain & Neurological Institute, by James R. Weintraub, D.O. The history provided indicated headaches and neck pain beginning with the rehabilitation from the shoulder surgery. Claimant had been treated to this point with biofeedback, bed rest, neuroblockade, physical therapy and a TENS unit. Dr. Weintraub diagnosed claimant with post-traumatic chronic headache, post-traumatic cervicalgia and probable post-trauma syndrome. He expressed concern that claimant's headaches were being aggravated by overuse of medication. Claimant was admitted to the Chelsea Community Hospital in Chelsea, Michigan, on March 31, 2008, for intense inpatient treatment. MRIs of the brain were read as mostly normal as was a CT scan performed in April 2008. An MRI of the cervical spine displayed cervical spondylosis and disc bulging at multiple levels with impact on the spinal cord at C3 through C6 levels. In June 2008, claimant was diagnosed with a substantial sleep disorder, having both hypoventilation and hypoxemia. Although how that impacts his headaches is not explained. An FCE was attempted on July 21, 2008, but discontinued when claimant reported increasing severity of headaches.

On August 19, 2008, claimant was given permanent restrictions by Dr. Divelbiss of a maximum 5 pound lift with the left arm and no above chest work with the left arm. Claimant advised Dr. Divelbiss that he could only sit for one hour, stand for 20 minutes and walk for 10-20 minutes. But, there were no restrictions from any medical records so limiting claimant's activities. In his report of March 3, 2009, Dr. Divelbiss rated claimant at 20 percent impairment to the left shoulder pursuant to the AMA Guides, 4th ed. The lifting restrictions remained. No impairment rating was given for the headaches as, in Dr. Divelbiss's opinion, those ratings were due to pre-existing conditions and not from the accident of January 7, 2004.

Claimant was referred by his attorney to board certified orthopedic surgeon William O. Hopkins, M.D., for an examination on October 20, 2009. Dr. Hopkins reviewed extensive medical records and obtained a history from claimant regarding the accident which is consistent with claimant's earlier testimony. On physical exam, claimant displayed a limited range of motion of the cervical spine due to pain. Claimant had also developed tingling and numbness in the left hand, primarily in the index and middle finger distribution. Claimant's left shoulder also displayed limited range of motion and tested weaker than the right shoulder. Claimant displayed atrophy of the left deltoid, supraspinatus and infraspinatus muscles with tenderness over the rotator cuff insertion of the left shoulder.

Dr. Hopkins determined that claimant had sustained a work-related injury to his neck and left shoulder, and initially to his rib cage which appears to have resolved. Claimant developed post-traumatic cervical headaches and was found to have preexisting degenerative disc and facet disease of his cervical spine. Claimant was diagnosed with post traumatic cephalgia as his most dominant and disabling symptom. Dr. Hopkins opined that the left shoulder, by itself, would not render claimant completely disabled. However, with the insertion of the headaches claimant would be rendered incapable of any work activity on a day-to-day basis. Dr. Hopkins found the treatment rendered to claimant to have been appropriate. In his follow-up letter, of February 10, 2010, Dr. Hopkins opined that it would not be uncommon for someone with chronic unresolved pain issues to undergo reactive depression which could affect all of his functions.

Claimant was referred by respondent to board certified internal medicine specialist Chris D. Fevurly, M.D., for an examination, on November 23, 2009. Dr. Fevurly was also provided with an extensive list of medical reports and records for his review. On examination, claimant reported constant headaches and neck pain. Claimant also had an intermittent left shoulder ache. Claimant reported that he has ceased most of his prior physical activities, including riding motor cycles, spending most of his time in sedentary activities.

A physical exam displayed no atrophy in any location, including the left shoulder. Claimant did display limited range of motion in the cervical spine. Range of motion in the left shoulder was normal, but claimant expressed pain with the extreme ranges of motion in the shoulder. Dr. Fevurly opined that claimant demonstrated mild pain behaviors with

the range of motion testing, but noted that the pain displays were not exaggerated. Dr. Fevurly opined that claimant's headaches were not causally related to the accident of January 7, 2004. Claimant's current major predictive factor for his chronic pain complaints is claimant's major depressive disorder. Dr. Fevurly also reported that claimant's psychological factors are major contributors to his current neck pain and headaches. Claimant was assessed a 5 percent whole person impairment, pursuant to the AMA Guides, 4th ed. as the result of the pain complaints. But, in Dr. Fevurly's opinion this impairment does not stem from the accident of January 7, 2004.

Claimant was referred to vocational expert Michael Dreiling, for an evaluation on August 18, 2010. Mr. Dreiling was provided with an extensive work history on claimant and was provided the medical reports from Drs. Weinstein, Ryan, Carabetta, Hughes, Weintraub, Silverman and Hopkins. Claimant indicated a life with limited physical activities, but does use a riding mower for up to 25 minutes at a time when not suffering from the headaches. Claimant experiences about two weeks of very debilitating headaches every month. He can drive a car and shop for his wife who is on Social Security Disability when not experiencing the headaches. Claimant has not applied for a job since the accident on January 7, 2004.

Mr. Dreiling ultimately opined that claimant is essentially and realistically unemployable in the open labor market and is completely and permanently incapable of engaging in any type of substantial and gainful employment as the result of his medical disabilities. The main causes of his limitations are the ongoing headaches and the need for significant medication on a regular basis. Claimant would not be a good candidate for vocational rehabilitation services as his prognosis is quite guarded.

PRINCIPLES OF LAW AND ANALYSIS

The Award sets out findings of fact and conclusions of law in some detail and it is not necessary to repeat those herein. The Board adopts those findings and conclusions as its own.

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.[3]

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[4]

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[3] K.S.A. 44-501 and K.S.A. 44-508(g).

[4] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

> If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act.[5]

Initially, claimant suffered an injury to his left shoulder which required surgical intervention. There was some testimony that claimant may have suffered an injury to his head at that time. But that testimony does not support a finding that the head injury resulted in the headaches that claimant currently experiences. However, the physical therapy that claimant attended for the shoulder injury appears to have caused or contributed to the headaches from the cervical trauma suffered during the therapy.

In workers' compensation litigation, when a primary injury under the Workers Compensation Act is shown to arise out of and in the course of employment, every natural consequence that flows from that injury, including a new and distinct injury, is compensable if it is a direct and natural result of the primary injury.[6] Injuries suffered from the effects of authorized medical treatment are also compensable in Kansas.[7]

As noted by the ALJ, the evidence supports a finding that claimant's headaches either arose from the original injury, or from the medical treatment for the shoulder injury. While the Board questions claimant's allegations that the original fall caused a head injury leading to the headaches, the testimony regarding the effects of the physical therapy are persuasive. Claimant underwent a significant surgery to his left shoulder. After the surgery, claimant attended physical therapy. Also, claimant developed swelling in and around the shoulder and supraclavicular region after this surgery. It was about this time, while claimant was being treated by Dr. Divelbiss, that the headaches started. Both Dr. Hopkins and Mr. Dreiling opined that claimant's headaches contributed to claimant's inability to retain or obtain employment in the open labor market. Dr. Weintraub testified that the cervicogenic headaches were connected to the multitude of medications claimant was using to combat his ongoing pain complaints.

Permanent total disability exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment.[8]

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[5] K.S.A. 44-501(a).

[6] *Jackson v. Stevens Well Service*, 208 Kan. 637, 493 P.2d 264 (1972).

[7] *Roberts v. Krupka*, 246 Kan. 433, 790 P.2d 422 (1990).

[8] K.S.A. 44-510c(a)(2).

The initial injury to claimant's left shoulder would not have resulted in his being permanently and totally disabled. However, the added complication of the ongoing and very debilitating headaches and the medications for that condition have resulted in claimant being significantly limited in his ability to work. Headaches which render a worker practically bedridden for 3-7 days at a time several times a month would prevent an employee from obtaining and retaining employment in the open labor market. Claimant is permanently and totally disabled and is realistically unemployable from the injuries suffered from and after the injury of January 7, 2004. The award by the ALJ is affirmed.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed. Claimant has satisfied his burden of proving that he is essentially and realistically unemployable as the result of the accident and resulting injuries from January 7, 2004.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Kenneth J. Hursh dated July 22, 2011, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of December, 2011.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: John E. Redmond, Attorney for Claimant
William G. Belden, Attorney for Respondent and its Insurance Carrier
Kenneth J. Hursh, Administrative Law Judge